PLAN DOCUMENT,
SUMMARY PLAN DESCRIPTION, AND
ADMINISTRATIVE WRAPPER

HANFORD EMPLOYEE
WELFARE BENEFIT PLANS

Offered under the
HANFORD EMPLOYEE
WELFARE TRUST (HEWT)

DATED JANUARY 1, 2016

This plan document and summary plan description contain information the Plan Administrator is required to provide to you under federal law.

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INTRODUCTION

This document is the formal plan document and summary plan description under which the welfare benefit plans (the "Plans") listed in Attachment A (the "Plans Chart") and offered under the Hanford Employee Welfare Trust (the "Trust") are administered. A separate document governs benefits provided to retirees and their dependents. As used in this document, "we," "us" and "our" refers to the Plan Administrator. "You" and "your" are referring to covered employees and their eligible dependents.

This document describes the Plans effective as of January 1, 2016, except to the extent changes in the law require an earlier effective date.

This document, along with the summary plan descriptions, benefit summaries, certificates of coverage and other plan documents (collectively, the "SPDs") contain important information about your rights and obligations under federal law and under the Plans and the procedures you need to follow if you have questions about your benefits or if you disagree with a decision on your claim for benefits.

Benefits under the Plans are provided through the Trust. The Trust has been adopted by the employers listed on Attachment B (the "Sponsors Chart"). They are the Sponsors of the Plans. You are receiving this document because your employer is one of the Sponsors of the Plans.

The Sponsors have appointed the Board of Trustees of the Trust as the Plan Administrator of the Plans. The Board of Trustees is the Plan Administrator. Other entities are involved in the insurance and/or administration of the Plans as well. These are described in the Plans Chart.

You have received additional summaries or SPDs governing the Plans in which you are eligible to participate either electronically or in writing, and if you received them electronically you are entitled to receive printed copies per a written request to the following address: HEWT, Attn: Plan Administrator (H2-23), Post Office Box 650, Richland, Washington 99352. The SPDs provide detailed information about the benefits to which you are entitled and steps you must take to obtain those benefits. The SPDs are incorporated herein by this reference. If there are conflicts between the language of the SPDs and this document, the terms of this document control. You may also request official additional insurance contracts, trust agreements and other documents, which legally govern the operation of the plans. This document is intended to be read in conjunction with the SPDs and other documents, except as otherwise expressly provided.

DESCRIPTION OF THE PLANS

The names of the Plans (and, if different, the name by which the Plans are commonly known), Plan number assigned by the Board of Trustees, and the types of the Plans (medical, dental, life, disability, etc.) are described in the Plans Chart (Attachment A).

PLAN SPONSORS

The names of the Sponsors, their addresses and their Employer Identification Numbers ("EINs") assigned by the Internal Revenue Service are described in the Sponsors Chart (Attachment B).

In addition, participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a Sponsor of the Plan and, if the employer is a Plan Sponsor, the Sponsor's address.

EMPLOYER IDENTIFICATION NUMBER AND PLAN IDENTIFICATION NUMBER

The Employer Identification Number assigned to the Trust by the Internal Revenue Service is 91-2017261. The Plan Identification Number is 550.

PLAN TRUSTEES

The name, title and address of the principal place of business of the trustees of the Plans is:

Board of Trustees of the Hanford Employee Welfare Trust
Mission Support Alliance, LLC
P.O. Box 650, MSIN: H2-23
Richland, WA 99352

PLAN ADMINISTRATOR

The designated Plan Administrator of the Plans is the Board of Trustees of the Trust. The rights, duties, powers, and authority of the Board of Trustees is described in the Hanford Employee Welfare Trust Agreement (the "Trust Agreement"). All of the Trustees are representatives of the Sponsors (including your Employer) who establish and maintain the Plans.

The name, address and telephone number of the Plan Administrator is:

Board of Trustees of the Hanford Employee Welfare Trust
P.O. Box 650, MSIN: H2-23
Richland, WA 99352
Attn: Rhonda Renz, Secretary
Telephone: (509) 372-8284

PLAN ADMINISTRATOR'S DISCRETION

In carrying out its responsibilities under the Plans, the Plan Administrator has the exclusive responsibility and full discretionary authority to control the operation and administration of the Plans and to make all fiduciary decisions under the Plans, and it has all power necessary to accomplish such purposes. These powers include, but are not limited to:

- To make and enforce such rules and regulations as in its sole and absolute and uncontrolled discretion it deems necessary or proper for the efficient administration of the Plans that are not inconsistent with the terms of the Plans or ERISA.

- To interpret the Plan documents in its discretion and its interpretation in good faith. Such interpretation is final and conclusive on all persons claiming benefits under the Plans.

- To use, employ, discharge or consult with one or more individuals, corporations or other entities with respect to advice regarding any responsibility, obligation or duty in connection with the Plan.

- To allocate fiduciary responsibilities by written instrument signed in the same manner as provided for delegations.

- To designate other individuals, corporations or other entities to carry out fiduciary responsibilities, obligations and duties under the Plan, and to revoke, modify or change any such delegation, revocation or modification by written instrument.

In carrying out its responsibilities, the Plan Administrator shall be fully protected to the fullest extent permitted under ERISA. In the event of any delegation in accordance with the above, no fiduciary shall be liable for any act or action, whether of commission or omission, taken by the person to whom the delegation is made. Fiduciary responsibilities shall be exercised severally and not jointly and each fiduciary's powers, duties, obligations and responsibilities shall be limited to those specifically allocated to such fiduciary or in accordance with the terms of this document.

PLAN RECORDS AND PLAN YEAR

The fiscal records for all Plans are maintained and reported on a twelve-month period of time, known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

SOURCE AND AMOUNT OF CONTRIBUTIONS

The source of contributions for each Plan is described in the Plans Chart (Attachment A). Depending on the Plan, contributions are made entirely by the Sponsors, entirely by the participants, or partly by the Sponsors and partly by the participants. Therefore, plan provisions and contribution structures are subject to change. The sponsors will determine, from time to time, what portion of the benefits will be paid directly by the Sponsors and what portion will be paid by the participants. Any amounts paid by a Sponsor will be paid out of such Sponsor's general assets.

The contributions structure for any plan may differentiate between rates for individuals who are "Incumbents" and those who are "Non-Incumbents." The definitions of these terms can be found in the Eligibility provisions of this Plan.

PAYMENT OF BENEFITS

How benefits are paid under each Plan (i.e., the method of payment of benefits) is described for each Plan in the Plans Chart (Attachment A). The Chart provides the name of any insurance company, trust fund or other institution, organization, or entity that maintains a fund on behalf of a Plan or through which a Plan is funded or benefits are provided.

You should read the Plans Chart to understand exactly how benefits are paid for each Plan in which you participate. However, the following provides some general background.

The primary function of the Trust is to receive and hold Sponsor and participant contributions to the Plans, to pay insurance premiums or claims under the Plans and Plan expenses, as applicable. However, the Trust is not solely responsible for payment of benefits under the Plans. Benefits are payable by the insurance company, the Sponsors (i.e., your Employer) or a combination of both, depending on whether the Plan is insured, self-insured or partly insured and partly self-insured.

Some of the Plans under which your benefits are provided are Insured, as described on the Plans Chart (Attachment A). This means that only the insurance company is responsible for payment of those benefits.

Some of the Plans under which your benefits are provided are Self-Insured by the Sponsors, as described on the Plans Chart (Attachment A). This means that only your Employer and the Trust are responsible for payment of those benefits. Sponsors other than your Employer are not responsible for payment of your benefits under the Self-Insured Plans.

DESCRIPTION OF BENEFITS

A description or summary of the benefits for each Plan is contained in a separate SPD or certificate of coverage. An SPD or certificate of coverage may also make reference to schedules of benefits. Applicable SPDs and or certificates of coverage are available without cost to any participant or beneficiary who so request.

ELIGIBILITY FOR BENEFITS

Subject to the exclusions below for certain listed employers, you are eligible to participate in the applicable Plans described in the Plans Chart (Attachment A) if you are an employee in a recognized employment status (i.e., active, personal or work-related disability, reduction of force, COBRA, service in the uniformed services as mandated by the Uniformed Services Employment and Reemployment Rights Act, and approved leaves of absence) with a Sponsor and are designated as a member of an eligible class (Attachment B).

You are an "active" employee if you are a regular full-time or part-time employee of one of the Sponsors, and are scheduled to work a minimum of 20 hours per week. There may be differences in coverage and contributions between actives based on their status as non-union or union represented.

Changes of employment status may also result in change of eligibility. See Change of Eligibility Chart (Attachment C).

There may be differences in eligibility and coverage for individuals who are "Incumbents" and those who are "Non-Incumbents." Generally, an "Incumbent Employee" is an Employee who is eligible to participate in the Hanford Multi-Employer Pension Plan, Hanford Operations and Engineering. A "Non-Incumbent Employee" is an Employee who is not an Incumbent Employee.

Both Incumbents and Non-Incumbent employees of Washington River Protection *Solutions*, LLC and CH2M HILL Plateau Remediation Company are eligible to participate in the HEWT.

If you are a non-bargained employee employed by an Employer listed below, you are only eligible to participate in the HEWT if you are an Incumbent Employee:

Mission Support Alliance, LLC; Akima Hanford Services, LLC; Dade Moeller & Associates Hanford Mission Support, LLC; HPM Corporation-MSA; and Westech International MSA, LLC.

If you are a non-bargained employee of Wastren Advantage, Inc., you are only eligible to participate in the HEWT if you are an Incumbent Employee.

Both Incumbent and Non-Incumbent Employees of Washington Closure Hanford, LLC are eligible to participate in the HEWT, but the contribution rate may vary.

All HAMTC and HGU-represented employees are eligible to participate in the HEWT.

Excluded Employees from participating in the HEWT:

Regardless of whether you are otherwise eligible:

- Temporary and hourly employees are not eligible to participate in the HEWT.

The effective date of your coverage is the date of acceptance of enrollment by the Plan Administrator. There is no waiting period for coverage. To obtain coverage, you must enroll within 31 calendar days immediately following the date of employment in an eligible class. Your dependents must be enrolled within the same time period. If you or your dependents are not enrolled when first eligible, you will be required to wait until the next annual enrollment period to elect coverage unless a special enrollment right is available to you. An annual enrollment period will be offered annually at such dates as the Plan Administrator shall determine. Special enrollment rights are available to you under the Health Plans offered by the Trust as required by federal law. See page 30, Special Enrollment Periods.

Medical/Prescriptions/Vision Plans

Your dependents, as defined below, are eligible to participate only as described in the Plans Chart (Attachment A). All dependents must also meet the requirements set forth below applicable to the type of dependent. A dependent may not be initially enrolled in a Plan unless you are enrolled in the Plan. Except as under prior agreement, no individual may be covered more than once under the HEWT sponsored plans.

Eligible dependents include:

- Your legal **spouse** or **domestic partner** (each as recognized by Washington State law), unless he or she is enrolled in one of the Plans as an employee or retiree.

- A child under age 26 (beginning January 1, 2015 coverage will continue through the month in which a child attains age 26).

The term child(ren) means: natural children, legally adopted children, stepchildren, and other children where you or your spouse/domestic partner has legal guardianship, custody, or conservatorship evidenced by a court order.

Dependents on military leave are not specifically excluded from coverage, but the Plan may be limited with respect to the coverage it may provide to dependents on military leave.

Your dependents are eligible for coverage from the date they join your family by reason of birth, legal adoption, placement for adoption, or marriage, provided you formally enroll them as covered dependents within 31 calendar days of the event.

Special rules apply to newborn or adopted children:

A newborn or adopted newborn dependent is automatically covered for 21 days following birth.

A newborn or adopted child may be enrolled retroactively within 60 days following date of birth or placement for adoption.

If no additional premium is required, enrollment is not required as a condition of coverage but claim reimbursement may be delayed until enrollment.

- Coverage can be continued for **child(ren) age 26 or more years old** if the child is not able to be self-supporting by reason of a **mental or physical handicap**, provided:

  - the handicap existed before age 26, and
  - the child was covered as a dependent prior to reaching age 26, and
  - the child is principally dependent on you for support, and
  - proof of the child's condition and dependence is submitted prior to the date coverage would otherwise have ended.

  Contact the Plan Administrator for details and required paperwork at least 60 days before your child attains age 26.

  We may require that the child be examined by a physician chosen by us at our cost. You may be required to continue to provide proof that the child meets the conditions of incapacity and dependency. If you do not provide proof of the child's incapacity and dependency within 30 days of request, coverage for the child will end.

If both you and your spouse/domestic partner are eligible to participate in a HEWT sponsored plan, each of you can enroll in a Plan as an employee, or one spouse/domestic partner can enroll as an employee and cover the other spouse/domestic partner as a dependent. Except where specifically authorized by prior agreement, coordination of benefits between any of the Company sponsored plans will not apply.

If both you and your spouse/domestic partner are covered under the Plan as employees, your children may be enrolled as dependents on one of your Plans, but not both.

No individual who is characterized by the Sponsor as an independent contractor (regardless of how that individual is classified under applicable state or federal law) is eligible. Participation in any of the Plans should not be viewed as a contract of employment.

Dental Plans

Your dependents, as defined below, are eligible to participate only as described in the Plans Chart (Attachment A). All dependents must also meet the requirements set forth below applicable to the type of dependent. A dependent may not be initially enrolled in a Plan unless you are enrolled in the Plan. Except as under prior agreement, no individual may be covered more than once under the HEWT sponsored plans.

Eligible dependents include:

- Your legal **spouse** or **domestic partner** (each as recognized by Washington State law), unless he or she is enrolled in one of the Plans as an employee or retiree.

- Your **child(ren)** in accordance with the following rules:

    - For benefits offered by Willamette Dental, a child who is under age 26

    - For benefits offered by Delta Dental, an unmarried child, under age 23, if you provide more than fifty percent (50%) of their support and maintenance, provided they are not:

        In active duty military service, or

        Employed full-time, or

        Eligible for any other group health benefits through their employer.

The term child(ren) means: natural children, legally adopted children, stepchildren, and other children where you or your spouse/domestic partner has legal guardianship, custody, or conservatorship evidenced by a court order.

Military Service means the performance of duty on a voluntary or involuntary basis in the uniformed services, including active duty, active and inactive duty for training, National Guard duty under federal statute, and any period for which a person is absent from employment for an examination to determine fitness to perform such duty. Uniformed services includes the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty; the Commissioned Corps of the Public Health Service; and any other category of persons designated by the President in time of war or national emergency.

Your dependents are eligible for coverage from the date they join your family by reason of birth, legal adoption, placement for adoption, or marriage, provided you formally enroll them as covered dependents within 31 calendar days of the event.

- Coverage can be continued for **unmarried child(ren) age 23** (for benefits offered by Delta Dental) or age 26 (for benefits offered by Willamette Dental) **or more years old** if the child is not able to be self-supporting by reason of a **mental or physical handicap**, provided:

    - the handicap existed before age 23 (or age 26, as applicable), and
    - the child was covered as a dependent prior to reaching age 23 (or age 26, as applicable), and
    - the child is principally dependent on you for support, and
    - proof of the child's condition and dependence is submitted prior to the date coverage would otherwise have ended.

    We may require that the child be examined by a physician chosen by us at our cost. You may be required to continue to provide proof that the child meets the conditions of incapacity and dependency. If you do not provide proof of the child's incapacity and dependency within 30 days of request, coverage for the child will end.

If both you and your spouse/domestic partner are eligible to participate in a HEWT sponsored plan, each of you can enroll in a Plan as an employee, or one spouse/domestic partner can enroll as an employee and cover the other spouse/domestic partner as a dependent. Except where specifically authorized by prior agreement, coordination of benefits between any of the Company sponsored plans will not apply.

If both you and your spouse/domestic partner are covered under the Plan as employees, your children may be enrolled as dependents on one of your Plans, but not both. A child cannot be covered as a dependent if that child is eligible for coverage as an employee under any Sponsor's group medical plan.

No individual who is characterized by the Sponsor as an independent contractor (regardless of how that individual is classified under applicable state or federal law) is eligible. Participation in any of the Plans should not be viewed as a contract of employment.

Life Insurance Plans

Basic Life/Accidental Death and Dismemberment, Dependent Life, Group Universal Life, and Personal Accident Insurance plans are available. For eligibility rules and definitions, refer to the applicable SPD or insurance contract.

Short-Term and Long-Term Disability Plans

Short-Term and Long-Term Disability Plans are available for employees. For eligibility rules and definitions, refer to the Short and Long Term Disability Plan SPD.

Flexible Spending Accounts (FSA)

Health Care and Dependent Care FSAs are available to eligible employees. For rules and definitions, refer to the Flexible Benefits Plan Document and Flexible Benefit Plan SPD.

Severance Pay Plan

There may be times when economic circumstances, financial conditions, reorganizations, or work slow down make it necessary to enact layoff procedures. For rules and definitions, refer to the Severance Pay Plan SPD.

MEDICAL COVERAGE PATIENT PROTECTIONS

If a medical benefit option requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If the medical plan option designates a primary care provider automatically, the Plan will designate one for you until you make a designation. For information on how to select a primary care provider, and how to obtain a list of the participating primary care providers, please refer to the applicable certificate of coverage or SPD.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Plan Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the benefit networks who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. You can locate health care professionals who specialize in obstetrics or gynecology by referring to the applicable certificate of coverage or SPD.

DISQUALIFICATION FOR BENEFITS

Your eligibility to participate in the applicable Plans will end:

- In accordance with the terms of the applicable SPD.
- When the Plan is discontinued or terminated.
- When you fail to make any required contribution within 45 calendar days after the due date.

- When you are no longer working in an eligible class.

- For an enrolled dependent, when he or she no longer meets the requirements to remain an eligible dependent (provided that a dependent's medical coverage will end at the end of the month in which the dependent attains age 26 if the dependent is not otherwise eligible for coverage).

- As a result of material misrepresentation, fraud, or omission of information in order to obtain coverage for a participant or others.

- For permitting the use of a plan's identification card or number by another person, or using another person's identification card or number in order to obtain benefits to which one is not entitled.

- In cases where a participant commits acts of physical or verbal abuse that pose a threat to the claim administrator, an insurance provider, or the plan administrator or staff.

Additional circumstances which may result in disqualification, ineligibility or denial, loss, forfeiture or suspension of any benefits are described in the Changes in Eligibility Chart (Attachment C).

TYPE OF PLAN ADMINISTRATION

The type of administration (contract administration, insurer administration, etc.) of each Plan is described in the Plans Chart. (Attachment A)

NAME AND ADDRESS OF AGENT FOR LEGAL PROCESS

The name and address of the agent for service of legal process for the Plans is:

Mr. Jason Froggatt
Davis Wright Tremaine LLP
Suite 2200
1201 3rd Avenue
Seattle, WA 98101

Legal process may also be served upon a Plan Trustee or the Plan Administrator.

PLAN DOCUMENTS

The Plan documents consist of this document, the summary plan descriptions, certificates of insurance/coverage, group insurance contracts, the Trust Agreement and the formal interpretations adopted by the Plan Administrator. Upon written request to the Plan Administrator, copies of any or all of the Plan documents will be furnished to a Plan participant or beneficiary at a charge to the requestor.

AMENDMENT AND TERMINATION OF THE PLANS

The Trust and the Sponsors have established the Plans with the bona fide intention and expectation that they will be continued indefinitely, but they reserve the right to terminate all or any of the Plans, in whole or in part, at any time, without liability. This includes, without limitation, the right to increase or decrease the Sponsors' contributions or the participants' contributions to all or any of the Plans, at any time, and to modify all or any part of the coverage with respect to any or all of the participants covered by a Plan or Plans. Any termination will be in accordance with the provisions of the Trust and the agreements under which the Sponsors adopted the Plans (the "Adoption Agreements"). Any amendment, modification or termination will be approved by the Trust and the Sponsors, as applicable, in accordance with the Trust Agreement, the Adoption Agreements, and the normal procedures of the Trust and the Sponsors for transacting business.

Upon termination or discontinuance of any Plan, you will not have any further rights, other than for the payment of benefits for covered losses or expenses incurred before such Plan was terminated. The amount and form of any final benefit you or your beneficiary receive will depend on the Plan Documents and the Plan Administrator's decisions.

CLAIMING BENEFITS

You or your beneficiary must file the appropriate forms to receive any benefits or to take any other action under any of the Plans, as described in the applicable SPD or certificate of insurance. Completed forms should be submitted to the appropriate entity described in the applicable SPD or certificate of insurance. Generally, you or your provider on your behalf will initiate a claim for benefits with the applicable party administering the benefit plan (the claims administrator or insurance company). Please review the SPD or certificate of insurance to determine exactly how to initiate a claim for benefits.

If there are no claim and/or review procedures set forth in the SPD or certificate of insurance, you may follow the procedure set forth below. In some instances, after you have exhausted your claim and appeal rights before the claims administrator or insurance company, you may be entitled to a final appeal to the Plan Administrator. Consult the applicable SPD or certificate of insurance.

APPEAL PROCEDURES

You generally have 180 days after receipt of an adverse benefit determination to request an appeal of the determination. Consult the applicable SPD or certificate of insurance.

Before you are entitled to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act, you must exhaust all of the claims review procedures described in the applicable SPD or certificate of insurance.

Health Benefits

Urgent Claims

If your appeal involves an urgent claim under the insured group health plan (currently administered by Group Health) that requires immediate action, all levels of appeal have been delegated to the claims administrator or insurance company that is responsible for paying claims**. The claims administrator or insurance company's decisions are conclusive and binding.** Consult the applicable SPD.

If your appeal involves an urgent claim under the self-insured group health plan (currently administered by UnitedHealthcare) that requires immediate action, your appeal must be made to the insurance company that is responsible for paying claims. If you are not satisfied with the insurance company's appeal decision and your claim is based in whole or in part on a medical judgment or involves a rescission of coverage, you may request an external review of your claim. Consult the applicable SPD.

Pre-Service and Post-Service Claims – Insured Health Benefits

If your appeal involves a non-urgent claim and you are participating in an insured group health plan (currently administered by Group Health), all levels of appeal have been delegated to the insurance company that is responsible for paying claims. The insurance company's decisions are conclusive and binding. Consult the applicable Certificate of Coverage.

Pre-Service and Post-Service Claims – Self-Insured Health Plan

If your appeal involves a non-urgent claim under the self-insured health plan (currently administered by UnitedHealthcare), your first level of the appeal is to the insurance company that is responsible for paying the claims.

If you are not satisfied with the first level appeal decision, you have the right, but are not required, to request a voluntary appeal to the Plan Administrator. You may also request an external review if your claim is based in whole or in part on a medical judgment or involves a rescission of coverage. Note that if your claim is eligible for an external review, you may, but are not required, to request a voluntary appeal before you submit your request for an external review. If you do not request a voluntary appeal, your external review request must be submitted to the Plan Administrator within 4 months from the receipt of the first level appeal decision. Consult the applicable SPD.

If you decide to request a voluntary appeal, your voluntary appeal request must be submitted to the Plan Administrator within 60 days from the receipt of the first level appeal decision, or, if later, within 180 days following the initial adverse benefit determination.

If you request a voluntary appeal to the Plan Administrator, you will be provided the following:

- The opportunity to submit written comments, documents, records and other information that were submitted to UnitedHealthcare in connection with your first (1^{st}) level appeal.

- To receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your appeal that are sufficient to enable you to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal.

- A review that takes into account all comments, documents, records and all other information relating to the claim submitted by you at the time of your first (1st) appeal to UnitedHealthcare.

- A review conducted by the Plan Administrator that does not afford deference to the initial adverse benefit determination.

- The Plan Administrator will identify all medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination without regard to whether the advice was relied upon.

- Any health care professional engaged for purposes of a consultation with respect to your appeal will be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination nor a subordinate of such individual.

The voluntary appeal process is subject to the following terms and conditions:

- The HEWT waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to a voluntary appeal.

- The HEWT agrees that any statute of limitations or other defense based on timeliness is tolled during the time that your voluntary appeal is pending, but only if you comply with the requirements for a voluntary appeal. If you elect not to submit a voluntary appeal or do not comply with the requirements for submitting a voluntary appeal, the statute of limitations starts to run when the decision for your first (1st) level appeal to UnitedHealthcare is issued.

- You may elect to submit a benefit dispute to a voluntary appeal only after you have exhausted the appeals process to the insurance company that is responsible for paying the claims;

- Upon request, the Plan Administrator will provide you with information relating to the voluntary level of appeal that is sufficient to enable you to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the your decision of whether to submit a benefit dispute to the voluntary level of appeal will have no effect on your rights to any other benefits under the plan and information about the applicable rules, your right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker (e.g., any financial or personal interests in the result or any past or present relationship with any party to the review process).

- The HEWT will not impose any fees or costs on you as part of the voluntary level of appeal.

You will receive notification of the Plan Administrator's decision on your appeal not later than 30 days after receipt by the Plan Administrator of your request for review unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time, in which you will be notified prior to the termination of the initial review period. Notice shall be provided to you in writing or electronically.

Pre-Service and Post-Service Claims – Insured Dental Benefits

If your appeal involves a non-urgent claim and you are participating in an insured group dental plan (currently administered by Willamette Dental), all levels of appeal have been delegated to the insurance company that is responsible for paying claims. The insurance company's decisions are conclusive and binding. Consult the applicable Certificate of Coverage.

Pre-Service and Post-Service Claims – Self-Insured Dental Benefits

If your appeal involves a non-urgent claim under the self-insured dental plan (currently administered by Delta Dental), your first level of the appeal is to the insurance company that is responsible for paying the claims.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal to the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days from the receipt of the first level appeal decision, or, if later, within 180 days following the initial adverse benefit determination. You will be provided the following:

- The opportunity to submit written comments, documents, records and other information that were submitted to Delta Dental in connection with your first (1st) appeal.

- To receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your appeal.

- A review that takes into account all comments, documents, records and all other information relating to the claim submitted by you at the time of your first (1st) appeal to Delta Dental.

- A review conducted by the Plan Administrator that does not afford deference to the initial adverse benefit determination.

- If the appeal is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

- The Plan Administrator will identify all medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination without regard to whether the advice was relied upon.

- Any health care professional engaged for purposes of a consultation with respect to your appeal will be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination nor a subordinate of such individual.

You will receive notification of the Plan Administrator's decision on your appeal not later than 30 days after receipt by the Plan Administrator of your request for review unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time, in which you will be notified prior to the termination of the initial review period. Notice shall be provided to you in writing or electronically.

In the case of an adverse decision on your request for review, the notice shall:

- Specify the reason or reasons for the adverse determination.

- Provide you with a reference to the specific Plan provisions on which the determination is based.

- Provide you with a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the review.

In the event that you are not satisfied with the disposition of your appeal, you are entitled to initiate a lawsuit under Section 502(a) of the Employee Retirement Income Security Act.

Pharmacy Benefit Program

If you are not satisfied with the disposition of your claim for benefits under the Pharmacy Benefit Program as administered by Express Scripts (ESI), contact ESI at 1-800-796-7518 to confirm claim denial. You have the right to two appeals to ESI.

If you are not satisfied with the first level appeal decision made by ESI, you have the right, but are not required, to request a voluntary appeal to the Plan Administrator. You may also request an external review if your claim is based in whole or in part on a medical judgment or involves a rescission of coverage. Note that if your claim is eligible for an external review, you may, but are not required, to request a voluntary appeal before you submit your request for an external review. If you do not request a voluntary appeal, your external review request must be submitted to the Plan Administrator within 4 months from the receipt of the first level appeal decision. Consult the applicable SPD.

If you decide to request a voluntary appeal, your voluntary appeal request must be submitted to the Plan Administrator within 60 days from the receipt of the first level appeal decision, or, if later, within 180 days following the initial adverse benefit determination.

If you request a voluntary appeal to the Plan Administrator, include the following information in your letter of appeal to the Plan Administrator:

- Patient's name and the identification number from the Prescription ID card
- The date(s) of service(s)
- Documentation from ESI denying claim
- The reason you believe the prescription should be covered under the Plan
- Any documentation or other written information to support your request

Send the written appeal and documentation to:

HEWT Plan Administrator
Attention: Appeals
P.O. Box 650 (H2-23)
Richland, WA 99352

You will be provided the following:

- The opportunity to submit written comments, documents, records and other information that were submitted to ESI in connection with your first (1st) appeal to ESI.
- To receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your appeal.
- A review that takes into account all comments, documents, records and all other information relating to the claim submitted by you at the time of your first (1st) appeal to ESI.
- A review conducted by the Plan Administrator that does not afford deference to the initial adverse benefit determination.
- The Plan Administrator will identify all medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination without regard to whether the advice was relied upon.
- Any health care professional engaged for purposes of a consultation with respect to your appeal will be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination nor a subordinate of such individual.

The voluntary appeal process is subject to the following terms and conditions:

- The HEWT waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to a voluntary appeal.

- The HEWT agrees that any statute of limitations or other defense based on timeliness is tolled during the time that your voluntary appeal is pending.

- You may elect to submit a benefit dispute to a voluntary appeal only after you have exhausted the appeals process to the insurance company that is responsible for paying the claims;

- Upon request, the Plan Administrator will provide you with information relating to the voluntary level of appeal that is sufficient to enable you to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the your decision of whether to submit a benefit dispute to the voluntary level of appeal will have no effect on your rights to any other benefits under the plan and information about the applicable rules, your right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker (e.g., any financial or personal interests in the result or any past or present relationship with any party to the review process).

- The HEWT will not impose any fees or costs on you as part of the voluntary level of appeal.

You will receive notification of the Plan Administrator's decision on your appeal of ESI's determination not later than 30 days after receipt by the Plan Administrator of your request for review unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time, in which you will be notified prior to the termination of the initial review period. Notice shall be provided to you in writing or electronically.

In the case of an adverse decision on your request for review, the notice shall:

- Specify the reason or reasons for the adverse determination.

- Provide you with a reference to the specific Plan provisions on which the determination is based.

- Provide you with a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the review.

In the event that you are not satisfied with the disposition of your appeal, you are entitled to initiate a lawsuit under Section 502(a) of the Employee Retirement Income Security Act.

Life Insurance

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Insurance Company within 60 days from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal. Once your request has been received by the Insurance Company, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the initial claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. You may also submit issues and comments that you feel might affect the outcome of the review. The Insurance Company has 60 days from the date it receives your request to review your claim and notify you of its decision. Under special circumstances, the Insurance Company may require more time to review your claim. If this should happen, the Insurance Company must notify you in writing that its review period has been extended for an additional 60 days. Once its review is complete, the Insurance Company must notify you, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

All Other Benefits

STD and LTD, and Flexible Spending Accounts claims appeal procedures are described in the applicable SPD.

RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA")

As a participant in the Plans, you are entitled to certain rights and protections under ERISA.

ERISA provides that all Plan participants are entitled to:

- Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan Documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

- Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents

may have to pay for such coverage. There is a detailed description of your COBRA rights at page 23 of this document.

This Plan does not contain any elimination or exclusionary period of coverage for preexisting conditions.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Publications Hotline of the Employee Benefits Security Administration.

SPECIAL PROVISIONS APPLICABLE TO GROUP HEALTH PLANS

The following provisions apply only to Plans that are group health plans (each of which is a "Health Plan"), and shall supersede any inconsistent provisions in the Summary Plan Descriptions for Health Plans. Group health plans include medical, vision, prescription drug, dental and employee assistance plan coverage, and to the extent applicable, the health care flexible spending account.

Healthcare – Rescission of Coverage

To the extent required by applicable law, a participant's coverage under a benefit that is a group health plan as defined in the Internal Revenue Code shall not be rescinded as described in Treasury Regulation Section 54.9815.2712T unless the participant (or a person seeking coverage on behalf of the participant) performs an act, practice or omission that constitutes fraud or unless the participant makes an intentional misrepresentation of material fact. Each participant whose coverage under a benefit provided under this Plan is rescinded pursuant to this provision shall be provided with at least 30 days advance written notice of such rescission.

Qualified Medical Child Support Order

If a Health Plan receives a qualified medical child support order recognizing the right of any child of an employee to enrollment under the Health Plan, such child shall be enrolled as required under the terms of the order. Qualified medical child support orders shall be administered in accordance with procedures adopted by the Plan Administrator. You may obtain without charge a copy of such procedures from the Plan Administrator.

Family and Medical Leave

If a Participant is on an unpaid leave to care for a newborn, to care for a child placed with the Participant for adoption or foster care, for a serious health condition of the Participant or the Participant's spouse, child or parent, or because of any qualifying exigency arising out of the fact that the spouse, child or parent of the Participant is on covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed forces, coverage for the Participant and eligible Dependents will be continued for up to twelve (12) weeks. The Employer will continue to pay its share for all group coverages. To maintain eligibility, the employee must continue to contribute the same share of cost of coverage that he or she would pay when not on leave.

Military Family Leave

If a Participant is on an unpaid leave to care for a service member who is the Participant's spouse, child, parent, or next of kin, as provided in 29 USC Section 2612, the coverage for the Participant and eligible Dependents will be continued for up to twenty-six (26) weeks. The Employer will continue to pay for coverage to the extent required by law. To maintain eligibility, the employee must continue to contribute the same share of cost of coverage that he or she would pay when not on leave.

Military Leave

Employees going into or returning from military service may elect to continue Health Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). These rights apply only to eligible employees and eligible dependents covered under the Health Plan before leaving for military service.

NOTE: Military Service means the performance of duty on a voluntary or involuntary basis in the uniformed services, including active duty, active and inactive duty for training, National

Guard duty under federal statue, and any period for which a person is absent from employment for an examination to determine fitness to perform such duty. Uniformed services includes the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty; the Commissioned Corps of the Public Health Service; and any other category of persons designated by the President in time of war or national emergency.

The maximum period of coverage of a person under such an election shall be the lesser of:

- The 24 month period beginning on the date that Uniformed Service leave commences; or

- The period beginning on the date that Uniformed Service leave commences and ending on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

A person who elects to continue Health Plan coverage may be required to pay up to 102% of the full contribution under the Health Plan, except a person on active duty for 30 days or less cannot be required to pay more than the employee's share, if any, for the coverage. Upon return to active employment, the employee's health coverage and that of the employee's eligible dependents will be reinstated. No exclusions or waiting periods may be imposed on the employee or the employee's eligible dependents. However, plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

Layoff and Displaced Worker Benefits

If you are laid off as a result of a reduction of force, you will be eligible for medical and vision coverage for you and your dependents under the "Displaced Worker Program," which is administered by the HEWT. You will be eligible for Displaced Worker Coverage only if no other health coverage is available and all required contributions are paid. During the first year, contributions are the same as required of an employee. During the second year, you must pay 50% of the COBRA rate for Medical/Vision. During the third year and thereafter, you must pay 100% of the COBRA rate for Medical/Vision. You will receive the Displaced Worker Benefit instead of any medical or vision continuation coverage under COBRA. The Displaced Worker Program does not provide dental coverage so you will be eligible for COBRA continuation coverage for dental.

Approved Leave of Absence

If you are on an approved leave of absence (other than for military service), coverage for you and your dependents may be continued, provided all required contributions are paid.

Disability

If you become disabled and qualify for disability benefits under your Employer's short-term or long-term disability program (or state industrial insurance), Health Plan coverage for you and your eligible dependents may be continued for the duration of the approved disability leave, until

a dependent no longer qualifies as such or until you are eligible for normal retirement, whichever first occurs. You must pay all required contributions that you would pay as an active employee. This period of coverage will be credited toward satisfying the maximum coverage provided under COBRA discussed below.

Other group coverages may also be continued during disability leave if you pay the required contributions that you would pay as an active employee. Dependent life and personal accident insurances may only be continued for one year from the last day of active employment.

Death

At the time of your death, medical, dental, vision and employee assistance program coverage for your eligible dependents may be continued for up to 36 months under COBRA. The required contributions are waived for the first three (3) months. After the first three (3) months of employer-paid COBRA coverage, your eligible dependents may elect to continue coverage under COBRA up to an additional 33 months if they pay the COBRA premiums.

The election for medical, vision and dental coverage must be in writing and within 31 calendar days after coverage would otherwise end. Once the employer-paid COBRA period ends, as described above, continued COBRA coverage is conditioned upon the eligible dependent's payment of required premiums.

Death of Retirement Eligible Employee (Applies to Employees hired before January 1, 2004).If at the date of your death you have attained age 55 and have 10 or more years of vesting service under the Hanford Multi-Employer Pension Plan, your surviving spouse or domestic partner will have three (3) months of coverage under the employee plan. After the first three (3) months of coverage, your surviving spouse or domestic partner will be covered under the retiree plan until your surviving spouse or domestic partner reaches age 65. Coverage under the retiree plan for your surviving spouse will end sooner if your surviving spouse re-marries.

Medical and vision coverage for your eligible dependent children will be determined based on whether you have a surviving spouse or domestic partner.

If you have a surviving spouse or domestic partner, your eligible dependent child will continue to be covered under the employee plan for three (3) months. After the first three (3) months of coverage under the employee plan, your eligible dependent child will be covered under the retiree plan (this does not apply to employees newly hired on or after January 1, 2004.) Coverage under the retiree plan will terminate on the earlier of the date your dependent child ceases to qualify as an eligible dependent under the Plan or the date that your surviving spouse re-marries.

If at the time of your death, you do not have a surviving spouse or domestic partner, your eligible dependent child will be eligible for continuation of coverage under COBRA. After the first three (3) months of employer-paid COBRA coverage, your eligible dependents may elect to continue coverage under the employee plan up to an additional 33 months if they pay the COBRA premiums.

Once a dependent child no longer qualifies as a dependent under the Plan, he or she may elect to continue coverage under COBRA if eligible.

Employer provided coverage may be credited toward satisfying the maximum coverage provided under COBRA discussed below.

COBRA Continuation Coverage Eligibility

Eligibility.

If you are an employee of the Employer and you are covered by the Health Plan, you have a right to elect COBRA continuation coverage if you lose your group health coverage under the Health Plan for either one of the two following qualifying events:

- A reduction in your hours of employment; or
- The termination of your employment (for reasons other than gross misconduct).

If you are the spouse of an employee and you are covered by the Health Plan, you have the right to elect COBRA continuation coverage for yourself if you lose your group health coverage under the Health Plan for any of the following four qualifying events:

- The death of your spouse;
- The termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to and enrolls in Medicare benefits under Title XVIII of the Social Security Act.

A dependent child of an employee covered by the Health Plan has the right to elect COBRA continuation coverage if the dependent child's group health coverage under the Health Plan is lost for any of the following five qualifying events:

- The death of the employee-parent;
- The termination of the employee-parent's employment (for reasons other than gross misconduct) or reduction in the employee-parent's hours of employment;
- The parents' divorce or legal separation;
- The employee-parent becomes entitled to and enrolls in Medicare benefits under Title XVIII of the Social Security Act; or
- The dependent ceases to be a "dependent child" under the Health Plan.

If a child is born or adopted by the covered employee or the employee marries during the period of COBRA continuation coverage, and the covered employee has elected COBRA continuation coverage, then the employee (or in the case of a newborn or newly adopted child, other guardian) may elect COBRA continuation coverage for the child, or, in the event of marriage, the new Spouse.

Electing COBRA Continuation Coverage.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The covered employee or a covered family member has the responsibility to provide written notice of the employee's divorce or legal separation, or a child losing dependent status under the Plan. This written notice must be provided to the Plan Administrator (as described below) within 60 days after the later of (1) the date of such an event, or (2) the date on which the affected employee or family member would otherwise lose coverage because of such event. If this notice is not given to the Plan Administrator within the required 60-day period, the affected employee or family member will not be entitled to elect COBRA continuation coverage.

If a covered employee or covered family member provides notice of the employee's divorce or legal separation, or a child losing dependent status under the Plan, and COBRA continuation coverage is not available, the covered employee or covered family member will be notified by the Plan Administrator that COBRA continuation coverage is not available.

The Employer has the responsibility to notify the Plan Administrator of the employee's death, the employee's termination of employment or reduction in hours, or the employee becoming entitled to and enrolling in Medicare under Title XVIII of the Social Security Act.

When the Plan Administrator is notified that one of these qualifying events has occurred, the Plan Administrator will in turn notify the appropriate individuals (also called "qualified beneficiaries") that they have the right to elect COBRA continuation coverage. COBRA continuation coverage must be elected by such individuals within sixty (60) days after the later of (1) the date that coverage under the Health Plan would otherwise terminate due to the qualifying event, or (2) the date that these individuals are provided with written notification of their right to elect COBRA continuation coverage. If COBRA continuation coverage is not elected within this 60-day period, the Health Plan coverage will end retroactive to the date that coverage would have otherwise ended due to the COBRA qualifying event, and the affected employee or family member will not be entitled to elect COBRA continuation coverage. While an election by a covered employee or covered spouse will be treated as an election of COBRA continuation coverage by the entire family, each family member may make a separate election as to COBRA continuation coverage. This means that a covered spouse or dependent child may elect COBRA continuation coverage even if the employee does not make that election. If a child is born to, or placed for adoption with, a covered former employee during the COBRA continuation coverage period and the covered employee has elected COBRA continuation coverage, then the employee may elect COBRA continuation coverage for that child provided that the covered former employee notifies the Plan Administrator within the Health Plan's normal enrollment window for newborn children, adopted children, or children placed for adoption. You (or your covered spouse or dependents) may elect COBRA continuation coverage

even if you (or your covered spouse or dependents) are covered under another group health plan or are entitled to Medicare prior to electing COBRA continuation coverage.

Duration of Coverage.

If continuation of coverage is elected, the Employer is required to provide COBRA continuation coverage which, at the time that coverage is being provided, is identical to the coverage provided under the Health Plan to similarly situated Health Plan participants who have not experienced a qualifying event (called "non-COBRA beneficiaries"). For example, if an employee dies leaving a spouse and two dependent children covered under the Health Plan, they would be entitled to the same benefits as the covered spouse and dependent children of an employee. If the benefits for similarly situated non-COBRA beneficiaries are modified, the changes will apply to those who have COBRA continuation coverage as well.

COBRA continuation coverage may be maintained for up to 36 months unless the group health coverage was lost due to the employee's termination of employment or a reduction in hours. In these two situations, COBRA continuation coverage may be maintained for up to 18 months. However, if the Social Security Administration determines that the covered employee, spouse or dependent child was disabled at any time during the first sixty (60) days of COBRA continuation coverage and such individual provides the Plan Administrator with a copy of that determination within sixty (60) days after it is made and before the 18-month period expires, then that 18-month coverage may be extended for an additional 11 months (for a total of 29 months after the date the COBRA continuation coverage began) for the disabled qualified beneficiary and other covered family members. In the case of a child born to, or placed for adoption with, a covered employee during the period of COBRA continuation coverage, the 60-day period (mentioned in the previous sentence) is measured from the child's date of birth or placement for adoption. Each covered employee or covered family member who is determined to be disabled (under Title II or XVI of the Social Security Act) at any time during the first 60 days of COBRA continuation coverage has the responsibility to: (1) inform the Plan Administrator within sixty (60) days after the date of that determination, and (2) if applicable, inform the Plan Administrator within thirty (30) days after the date of any final determination that the covered employee or covered family member is not disabled.

Covered dependents who were covered by the Health Plan prior to the employee's termination of employment or reduction in hours and who are receiving COBRA continuation coverage, and any child born to the covered employee or placed with the covered employee for adoption and enrolled in the Health Plan while the covered employee is receiving COBRA continuation coverage, will be eligible to extend the initial 18-month COBRA continuation period (or if applicable, the 29-month COBRA continuation period) if one of the following events occurs during that 18-month period (or if applicable, the 29-month COBRA continuation period):

(1) the covered employee's death;

(2) the covered employee's divorce or legal separation;

(3) the covered employee becomes entitled to and enrolls in Medicare benefits; or

(4) a dependent child ceases to be a dependent under the terms of the Health Plan.

In any of the four situations described above, the covered dependents may extend their COBRA continuation coverage for up to 36 months from the date the covered employee terminated employment or lost Health Plan coverage because his or her hours were reduced. We ask that the covered employee or a covered family member inform the Plan Administrator of the employee's divorce or legal separation, or a child losing dependent status under the Health Plan within 60 days after the occurrence of such event. A family member whom the covered employee first enrolls during an annual enrollment period or special enrollment period while the covered employee is receiving COBRA continuation coverage is not eligible to extend the COBRA continuation period as described in this paragraph, unless that family member is a child born to the covered employee or placed with the covered employee for adoption and enrolled in the Health Plan while the covered employee is receiving COBRA continuation coverage.

If a covered employee becomes entitled to Medicare while employed by the Employer, and within eighteen (18) months after the employee becomes entitled to Medicare, he or she loses group health plan coverage due to the employee's termination of employment or reduction in hours, then the employee's covered spouse and covered dependents may elect COBRA continuation coverage for a period beginning with that loss of coverage and ending 36 months after the date the employee became entitled to Medicare.

In general, you and your covered dependents (if any) will only be given an opportunity to continue the coverage you each were receiving immediately before the qualifying event. In a few circumstances, however, you may elect alternative coverage, such as:

(1) If you participate in a region-specific HMO that will not service your health needs in the area to which you are relocating, you must be given an opportunity to elect alternative coverage that the employer makes available to employees.

(2) You and your covered dependents (if any) will have the same opportunity as an employee to change your coverage at annual enrollment, add new family members, or drop dependents.

(3) A qualified beneficiary who has elected COBRA continuation coverage may elect to cover certain family members under special enrollment rights if certain requirements are satisfied.

In general, there are special enrollment rights for certain family members upon the loss of other group health plan coverage or upon the acquisition by the employee or participant of a new spouse or of a new dependent through birth, adoption, or placement for adoption. Please refer to the Health Plan's summary plan description for further details on those special enrollment rights. Please note that a family member whom you first enroll during an annual enrollment period or special enrollment period while you are receiving COBRA continuation coverage and who was not covered by the Health Plan on the day before the initial COBRA qualifying event occurred is not eligible to extend the initial COBRA continuation period as described in this notice, unless that family member is a child born to the covered employee or placed with the covered employee for adoption during the initial 18-month period of COBRA continuation coverage and enrolled in the Health Plan while the covered employee was receiving COBRA continuation coverage.

When COBRA Continuation Coverage Ends.

The law provides that COBRA continuation coverage will end before the expiration of the 18, 29, or 36-month period for any of the following reasons:

(1) The Employer no longer provides group health coverage to any of its employees;

(2) The premium for the COBRA continuation coverage is not paid on a timely basis. (The first premium payment is payable in a lump sum forty-five (45) days after electing COBRA continuation coverage; all subsequent premium payments are due on the first day of the month. There is a 45-day grace period for premium payments. Premium payments must be paid no later than forty-five (45) days after the first day of the month to which they apply.);

(3) The covered individual first becomes, after the date of the COBRA continuation coverage election, covered under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any pre-existing condition of that individual (other than an exclusion or limitation that does not apply to, or is satisfied by, such individual by reason of the Health Insurance Portability and Accountability Act of 1996);

(4) The covered individual first becomes, after the date of the COBRA continuation coverage election, entitled to and enrolls in Medicare (under Title XVIII of the Social Security Act);

(5) When coverage has been extended from 18 to 29 months, the Social Security Administration makes a final determination that an individual is no longer disabled (under Title II or XVI of the Social Security Act); or

(6) Upon the occurrence of any event (such as submission of fraudulent claims) by a covered individual that permits termination of Health Plan coverage for cause with respect to similarly situated non-COBRA beneficiaries.

If your COBRA continuation coverage ends before the expiration of the 18, 29, or 36-month period, the Plan Administrator will provide you notice of termination of coverage as soon as practicable.

In the case of the event listed in number (5) above, a disabled individual is required to provide written notice to the Plan Administrator within thirty (30) days after the date of any final determination that the covered employee or covered family member is not disabled. Covered individuals should provide written notice to the Plan Administrator if an event occurs that is listed in number (3) or (4) above within thirty (30) days after becoming eligible for such other group health plan coverage or entitled to Medicare.

In the event that you fail to timely notify the Plan Administrator that you are no longer eligible for COBRA coverage as a result of events described in either paragraph numbers (3), (4) or (5), the Plan has the right to seek reimbursement for any benefits provided to you by the Plan during the period you were not eligible for coverage.

Special Rule for Health FSA.

Under the Health Care Flexible Spending Account Plan (the "health FSA"), you may elect to pay for your uninsured medical expenses and the uninsured medical expenses of your spouse and dependents (if any) with before-tax dollars. If you have elected to make contributions to the Health FSA, you may be entitled to elect COBRA continuation coverage for that plan. Generally, you and your covered spouse and your covered dependents are entitled to COBRA continuation coverage under the Health FSA until the end of the plan year in which the qualifying event occurs. However, COBRA continuation coverage is not available at all under the Health FSA if, as of the date of the qualifying event, the maximum benefit available to you or your covered spouse or dependents under the Health FSA for the remainder of the plan year is not more than the maximum amount that the plan could require to be paid as a premium for the remainder of that year for COBRA continuation coverage (this would occur, for example, if you had "overspent" your Health FSA account as of the date of the qualifying event).

Cost of Coverage.

The cost of COBRA continuation coverage will generally not exceed 102% of the cost to the Employer for coverage under the Health Plan. The cost of COBRA continuation coverage will increase in the middle of the 12-month determination period only in the following instances:

(1) where coverage extends beyond 18 months for a disabled individual, the cost of COBRA continuation coverage will be 150% of the applicable premium,

(2) where the qualified beneficiary changes to more expensive coverage, or

(3) where the Health Plan was previously requiring payment of less than the maximum permissible amount.

An individual seeking COBRA continuation coverage is liable for the cost of that coverage during the entire applicable 18-, 29-, or 36-month period (measured from the date that coverage would otherwise end due to the qualifying event). Due to the required sixty (60) day COBRA election period, it is likely that a covered individual will be responsible for retroactive premiums. These premiums must be paid in a lump sum within forty-five (45) days after electing COBRA continuation coverage in order for the COBRA continuation coverage to be effective. After that payment, premiums are due on the first day of each month. COBRA coverage will terminate if premiums are not paid within forty-five (45) days after the date they are due.

An individual need not show proof of insurability to elect COBRA continuation coverage.

Effect of COBRA Continuation Coverage on Other Rights Under Federal Law.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you may lose the right to avoid having preexisting condition exclusions applied to you by other group health plans. If you have more than a 63-day gap in health coverage, an election of continuation coverage may help you not to have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time

available to you. Finally, you should take into account that you may have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Coverage Expires.

When COBRA continuation coverage expires after 18, 29 or 36 months, an individual may have the opportunity to enroll in an individual conversion health plan by the Health Plan provided such option is otherwise generally available to similarly situated non-COBRA beneficiaries under the group health plan.

If You Have Questions.

Questions concerning your health plan or your COBRA continuation rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefit Security Administration (EBSA), or visit the EBSA website at www.dol.gov/ebsa.

Notices to the Plan Administrator.

Any notices that an employee or covered family member must make to the Plan Administrator (including notice of the employee's divorce or legal separation, or a child losing dependent status) should be delivered to the following address:

HEWT Plan Administrator
P.O. Box 650, MSIN: H2-23
Richland, Washington 99352-1000
Attn: COBRA Administrator

When providing notification to the Plan Administrator of the employee's divorce or legal separation, or a child losing dependent status, you must complete a Notice of Qualifying Event Form. The Notice of Qualifying Event Form is available from the Plan Administrator.

Address Changes.

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices you send to the Plan Administrator.

Conversion Privilege

A conversion privilege may be available if, at termination of your coverage under the Plan, you are participating in an insured health plan such as a plan offered by an HMO. There is no

conversion privilege offered under the self-insured medical plan provided by the Trust. If a conversion privilege exists, it will be described in the applicable SPD or certificate of insurance. Generally, if a conversion privilege is available, you may, within 31 calendar days following termination of coverage, apply for an individual health insurance policy, and the policy will be issued to you without medical examination. The policy may also be available to any of your dependents covered under the Plan on the date coverage ends. The policy issued, if any, will be that which is offered by the particular insured plan at the time of application. Coverage will become effective the day after the day coverage under this Plan terminates. A conversion policy may also be available to your spouse upon the annulment or dissolution of your marriage, or your death, provided your spouse applies within 31 calendar days after coverage terminates. For details with respect to the availability of a conversion policy, see the applicable SPD.

Benefits After Covered Mastectomy.

After a covered mastectomy, the Health Plan will cover the medical and surgical benefits for the following:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses (implants, special bras, etc.) and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes) in a manner determined appropriate in consultation with the attending physician and the patient.

Coverage for breast reconstruction and related services will be subject to all applicable deductibles, co-payments and coinsurance amounts that are consistent with those that apply to other benefits under the Health Plan.

The Health Plan will at all times comply with the terms of the Women's Health and Cancer Rights Act of 1998 and will not deny a patient eligibility, or continued eligibility to enroll or to renew coverage, under the terms of the Health Plan solely to avoid the requirements of this section. Additionally, the Health Plan will not penalize the patient or physician, or induce him or her to provide care to a participant in a manner inconsistent with this provision.

Any Health Plan exclusions or limitations that exclude the benefit described above are hereby omitted to the extent that they specifically prohibit the above coverage.

Mental Health Benefits.

Benefits under a Health Plan shall be provided in compliance with the Mental Health Parity and Addiction Equity Act of 2008.

Newborns' and Mothers' Health Protection Act of 1996

For Insured Plans that provide maternity or newborn infant coverage, special rights upon childbirth under the Newborns' and Mothers' Health Protection Act of 1996, as amended, and state law, as applicable, are described in the SPDs for the applicable Insured Plan. For Self-Insured Plans that provide maternity or newborn infant coverage, special rights upon childbirth are described below:

Special Rights Upon Childbirth: Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Privacy

The Health Plan is required by law to protect the privacy of certain health information that it may use or disclose. Employees will be provided with a Notice of Privacy Practices within 90 days of enrollment in the Health Plan that describes how the Health Plan may use or disclose your health information, your rights with respect to your health information, and the Health Plan's duties with respect to your health information. To get a copy of the notice, or if you have questions regarding the protection of your health information, you may contact the Health Plan Privacy Officer at (509) 372-8284.

Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

HIPAA prohibits discrimination against you based on your health status and provides you special enrollment rights. HIPAA also specifies certain privacy protections for your health information used or disclosed by the Health Plan. If you are unsure whether a particular plan is a Health Plan subject to HIPAA, please contact the Plan Administrator.

Preexisting Condition Limitations

There are no preexisting condition limitations in the Health Plans.

Nondiscrimination

Eligibility for benefits under the Health Plan will not be conditioned on any health status related factors such as health status, medical history, evidence of insurability, claims history, or genetic information. The Health Plan will not charge a contribution that is greater than the charge for a similarly situated individual based on any health status related factor. The Health Plan may offer premium discounts for a bona fide wellness program.

Special Enrollment Periods

Federal law requires Health Plans to provide "Special Enrollment Period" for certain individuals who previously refused coverage or individuals who became dependents through marriage, birth, adoption, or placement for adoption (as described further below). A person who enrolls during a Special Enrollment Period is not considered a "late plan participant" for purposes of the Health Plan.

The Health Plan will provide a Special Enrollment Period for an employee, spouse, domestic partner or dependent who is eligible, but not enrolled in the Health Plan, if each of the following conditions is met:

- He or she is eligible, but not enrolled, for coverage under the terms of the Health Plan;

- He or she had other health plan coverage at the time coverage was previously offered;

- He or she states in writing when declining enrollment that the other coverage was the reason for declining enrollment (if required by the Plan Administrator at the time the individual previously declined enrollment);

- He or she loses coverage because (1) his or her COBRA continuation coverage expires, (2) the employee or dependent is no longer eligible for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, but not including as a result of failure to pay premiums on a timely basis or termination of coverage for cause); or (3) the employer ceases making contributions toward such coverage; and

- He or she requests a special enrollment right within thirty days after the exhaustion or termination of other coverage.

After an employee, spouse, domestic partner or dependent gives the completed request of enrollment to the Plan Administrator, his or her enrollment is effective no later than the first day of the next calendar month.

The Health Plan will also provide a Special Enrollment Period for an employee or dependent as follows:

- For an employee who is eligible but not enrolled in the Health Plan and declined coverage under the Health Plan during a prior Enrollment Period, (1) at the time of his or her marriage, and (2) at the time an individual becomes his or her dependent through marriage, birth, adoption, or placement for adoption;

- For a spouse of a participant (1) at the time of his or her marriage or (2) at the time an individual becomes a dependent of the participant through birth, adoption, or placement for adoption;

- For an individual who becomes a dependent of the participant through marriage, birth, adoption, or placement for adoption.

The Special Enrollment Period will extend for 30 days after the marriage, birth, adoption, or placement for adoption. For a Special Enrollment due to marriage, enrollment is effective no later than the first day of the month following the date the Employer receives the request for enrollment. For a special enrollment due to birth, adoption, or placement for adoption, enrollment is effective as of the date of the birth, adoption, or placement for adoption.

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage.

An individual seeking enrollment during a Special Enrollment Period may be required to provide documentation of the event that qualifies him or her for the Special Enrollment Period.

CHIPRA Special Enrollment Rights and Premium Subsidy Notice

The Children's Health Insurance Program Reauthorization Act, "CHIPRA" is a federal law that was enacted in 2009 and provides healthcare coverage for low income uninsured children and eligible adults. Under the new law, eligible employees and their dependents may be eligible for enrollment in certain HEWT plans when:

- An employee or dependent loses coverage under Medicaid or CHIP because of ineligibility and is eligible and requests coverage under the HEWT, or

- The employee or dependent becomes eligible for state premium assistance (under Medicaid or CHIP) for coverage provided under the HEWT.

An individual meeting the above criteria has 60 days from the date of the qualifying Medicaid or CHIP event to request coverage. Eligible employees and their dependents may also be eligible for state premium assistance.

Attachment A

PLANS CHART

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
1. United HealthCare Options Preferred Provider Organization Plan ("PPO") This Plan covers all eligible employees. Eligible dependents may be covered; see the Eligibility section. Plan No. 550	Health, vision, mental health and substance abuse, and prescription drug benefits. Contract Administration for health, mental health and substance abuse by United HealthCare Insurance Company. Contract Administration for Prescription drug benefit by Express Scripts. Contract Administration for vision by United Healthcare Vision.	Sponsors Participants	Self-insured by your Employer (i.e. benefits are paid from employee contributions, if any, and the Employer's general assets) and are funded through the Hanford Employee Welfare Trust. United HealthCare Insurance Company provides administrative services only for health benefits. Vision benefits are provided through United HealthCare Vision. United Behavioral Health provides administrative services only for behavioral care. United HealthCare Insurance Company's administrative services include claim administration, cost containment, financial, banking and billing administration. All such services include payment of claims. These service providers do not insure any of the benefits. Express Scripts provides administrative services only for retail and mail order prescription drug benefits. United HealthCare Insurance Company's address for health, mental health, and substance abuse is: P.O. Box 30555 Salt Lake City, UT 84130-0555

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
			For Vision: United HealthCare Insurance Company's address is: P.O. Box 30978 Salt Lake City, UT 84130-0555 Express Scripts' address is: Express Scripts P.O. Box 390873 Bloomington, MN 55439 United Behavioral Health's address is: United Behavioral Care P.O. Box 30555 Salt Lake City, UT 84130-0555
2. GH Options Point-of-Service Plan This covers eligible employees. Plan No. 550 Eligible dependents may be covered; see the Eligibility	This provides health, vision, prescription drug and mental health and substance abuse benefits. Insurer administration	Sponsors Participants	Insured. GH insures the benefits through an insurance policy. It also administers the plan, including payment of claims. GH's address is: Group Health Cooperative 7601 W. Clearwater Ave. Suite 205 Kennewick, WA 99336

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
section.			
3. Willamette Dental of Washington ("WDW") Plan This covers eligible employees. Plan No. 550 Dependents may be covered; see the Eligibility section.	This provides dental care benefits. Insurer administration	Sponsors Participants	Insured. WDW insures the benefits through an insurance policy. It also administers the plan, including payment of claims. WDW's address is: Willamette Dental of Washington, Inc. 6950 NE Campus Way Hillsboro, OR 97124
4. Delta Dental Plan This covers eligible employees. Plan No. 550	This provides dental care benefits. Contract Administration for dental benefits by Delta Dental.	Sponsors Participants	Self-insured by your Employer (i.e. benefits are paid from employee contributions, if any, and the Employer's general assets) and are funded through the Hanford Employee Welfare Trust. Delta Dental administers the plan, including payment of claims.

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
Dependents may be covered; see the Eligibility section.			Delta Dental's address is: Delta Dental P.O. Box 75688 Seattle, WA 98175-0688
5. CIGNA Basic Life/Accidental Death & Dismemberment ("AD&D") Plan and Accelerated Death Benefit Plan This covers eligible employees. Plan No. 550	This provides life and accidental death and dismemberment benefits. Insurer administration	Sponsors Participants	Insured. CIGNA insures the benefits through an insurance policy. It also administers the plan. CIGNA's administrative services include: claim administration, cost containment, financial, banking, billing administration and payment of claims. CIGNA's address is: Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235
6. CIGNA Dependent Life Insurance Plan Plan No. 550 Eligible dependents of	This provides dependent life benefits. Insurer administration	Participants	Insured. CIGNA insures the benefits through an insurance policy. It also administers the plan. CIGNA's administrative services include: claim administration, cost containment, financial banking, billing administration and payment of claims. CIGNA's address is:

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
eligible employees may be covered; see the Eligibility section.			Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235
7. CIGNA Personal Accident Insurance Plan This covers eligible employees. Plan No. 550 Eligible dependents may be covered; see the Eligibility section.	This provides accident insurance benefits. Insurer administration	Participants	Insured. CIGNA insures the benefits through an insurance policy. It also administers the plan. CIGNA's administrative services include: claim administration, cost containment, financial banking, billing administration and payment of claims. CIGNA's address is: Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
8. Short Term Disability Plan This covers eligible employees. Plan No. 550	This provides short term disability benefits. Self-administration and insurer administration	Sponsors Participants	Partially insured, and partially self-insured by your Employer (i.e. benefits are paid from employee contributions, if any, and the Employer's general assets) and are funded through the Hanford Employee Welfare Trust. After the waiting period, if applicable, and through the 35th day of disability, this benefit is self-insured and administered by your Employer (except for Johnson Controls, Inc.) in an amount up to 60% of base salary to a maximum of $4,000 per week. Thereafter, CIGNA insures up to 60% of base salary to a maximum of $4,000 per week under an insurance policy. CIGNA administers the plan after day 35. CIGNA's administrative services include: claim administration, cost containment, financial banking, billing administration and payment of claims. Participants who have been continuously employed since December 31, 1997 may have salary continuance available in addition to the 60% of salary that is paid by STD. The salary continuance supplements up to 100% of pay. The amount of supplement available is based on hours grandfathered on December 31, 1997. This can only be used for short-term disability, and is not renewable after use. CIGNA's address is: Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
9. Long Term Disability Plan This covers eligible employees. Plan No. 550	This provides long term disability benefits. Insurer administration	Sponsors	Partially insured, and partially self-insured by your Employer (see below). CIGNA insures benefits for participants who went on disability prior to 1991 through an insurance policy. The Sponsors self-insure benefits for participants who went on disability in and after 1991. CIGNA also administers the plan. CIGNA's administrative services include: claim administration, cost containment, financial banking, billing administration and payment of claims. CIGNA's address is: Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
10. Business Travel Plan This covers eligible employees. Plan No. 550	This provides accident benefits. Insurer administration	Sponsors	Insured. CIGNA insures benefits through an insurance policy. It also administers the plan. CIGNA's administrative services include: claim administration, cost containment, financial banking, billing administration and payment of claims. CIGNA's address is: Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235
11. Health Care Flexible Spending Account Plan This covers eligible employees. Plan No. 550	This provides health care reimbursement benefits. Contract administration	Participants	Source of payment is limited solely to employee contributions. Johnson Controls, Inc. does not offer the Health Care Flexible Spending Account. United HealthCare administers the plan. Their administrative services include: claim administration, financial banking, billing administration and payment of claims. United HealthCare's address for FSA is: United HealthCare P.O. Box 981178 El Paso, TX 79998-1178

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
12. Dependent Care Flexible Spending Account Plan This covers eligible employees. Plan No. 550	This provides dependent care reimbursement benefits. Contract administration	Participants	Source of payment is limited solely to employee contributions. United HealthCare administers the plan. Their administrative services include: claim administration, financial banking, billing administration and payment of claims. Johnson Controls, Inc. does not offer the Dependent Care Flexible Spending Account. See Item 11 for UHC's address for FSAs.
13. Severance Pay Plan This covers eligible employees. Plan No. 550	This provides severance pay benefits	Sponsors	Company provided, where applicable.

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
14. Employee Assistance Plan This covers eligible employees. Plan No. 550	This provides resources and tools to help you enhance your work, health, and life. Contract administration	Sponsors	Insured. United Behavioral Health administers the Plan. Services include referrals and access to counselors or mental health therapists. 1-800-788-5614 or 1-866-216-9926 for TDD or log on to: www.liveandworkwell.com using access code 702633 United Behavioral Health's address is: United HealthCare P.O. Box 30555 Salt Lake City, UT 84130-0555
15. Group Universal Life Insurance*	This provides portable life insurance for employee and eligible dependents. Insurer administration	Participants	Insured. Benefits provided through an insurance policy. Mercer administers the policy and it is underwritten by CIGNA. Employer provided automatic payroll deduction. Employee may continue the benefit directly with Mercer after leaving employment. Mercer Voluntary Benefits P.O. Box 9122 Des Moines, IA 50306-9122

* Group Universal Life Insurance is not subject to ERISA, but it is a benefit plan offered under the HEWT and described herein for your convenience.

Attachment B

SPONSORS CHART

Name of Sponsor	Employer Identification Number	Address	Eligible Class
Washington Closure Hanford LLC	20-1666939	2620 Fermi Avenue Richland, WA 99354	HAMTC Represented and Salaried Exempt and Non-Exempt
Johnson Controls, Inc.	39-0380010	P.O. Box 750 Richland, WA 99352	HAMTC Represented
Energy Northwest (Standards Lab)	91-6018049	P.O. Box 968 North Power Plant Loop Richland, WA 99352	HAMTC Represented
Wastren Advantage, Inc.	82-0448833	699 Emory Valley Rd, Suites A & B Oak Ridge, TN 37830	HAMTC Represented and Salaried Exempt and Non-Exempt
CH2M Hill Plateau Remediation Company (CHPRC)	77-0694488	P.O. Box 1600, H8-17 Richland, WA 99352	Salaried Exempt and Non-Exempt (Incumbent and Non-Incumbent) HAMTC Represented
Washington River Protection *Solutions*, LLC	26-0771181	1200 Jadwin Avenue Richland, WA 99352	Salaried Exempt and Non-Exempt (Incumbent and Non-Incumbent) HAMTC Represented
Mission Support Alliance, LLC	30-0419594	P. O. Box 650, H2-23 Richland, WA 99352	Salaried Exempt and Non-Exempt (Incumbent) HAMTC Represented HGU Represented
Akima Hanford Services, LLC	27-0476876	2490 Garlick Blvd. Richland, WA 99354	Salaried Exempt and Non-Exempt (Incumbent) HAMTC Represented
Dade Moeller & Associates Hanford Mission Support, LLC	27-0470310	1835 Terminal Drive Richland, WA 99354	Salaried Exempt and Non-Exempt (Incumbent) HAMTC Represented

Name of Sponsor	Employer Identification Number	Address	Eligible Class
HPM Corporation – MSA	80-0433252	2625 W. Entiat Avenue Kennewick, WA 99336	Salaried Exempt and Non-Exempt (Incumbent)
Westech International MSA, LLC	27-0481996	825 Jadwin Avenue MSC A6-06 Richland, WA 99352	Salaried Exempt and Non-Exempt (Incumbent)

Attachment C

CHANGE OF ELIGIBILITY

Benefit Plan	If You Are Laid Off (Reduction of Force – ROF)	If Your Employment Terminates	If You Retire (age 55 with 10 years of vesting service, hired prior to 1/1/2004)	Leave of Absence	If You Are on Disability	If You Die
Medical/Vision						
United HealthCare Options Preferred Provider Organization Plan ("PPO")and Group Health Options Point of Service Plan ("POS")	May be eligible to continue Medical/Vision coverage for self and dependents until/unless eligible for coverage under another group health plan or Medicare. Year 1: Same cost as paid by employees for Medical/Vision. Year 2: 50% of COBRA rate for Medical/Vision, if eligible, for one year. Year 3: 100% of COBRA rate for Medical/Vision, if eligible.	Can continue your personal/dependent Medical/Vision coverage for up to 18 months under provisions of COBRA.	If eligible, may enroll in retiree medical plan.	Can continue your Medical/Vision coverage for self and dependents for duration of leave. Family Leave: Same cost as paid by employees for Medical/Vision. Personal Leave/Education Leave: Pay COBRA rates for Medical/Vision. Military Leave: in most cases, pay COBRA rates for Medical/Vision.	Medical/Vision coverage continues for you and eligible dependents at the same rate as employees as long as you continue to qualify for disability and you pay the required premium.	Medical/Vision can continue for dependents for up to three (3) months. In addition, if you are early retirement eligible (age 55 with 10 vesting years) at the time of your death, dependents can continue medical coverage under retiree provisions, with the exception of employees newly hired after January 1, 2004).
Dental						
Willamette Dental of	May be eligible to	Can continue under	Can continue under	Can continue for	Dental coverage can	Dependent dental

Benefit Plan	If You Are Laid Off (Reduction of Force – ROF)	If Your Employment Terminates	If You Retire (age 55 with 10 years of vesting service, hired prior to 1/1/2004)	Leave of Absence	If You Are on Disability	If You Die
Washington, Inc. Plan, and Delta Dental Plan	continue for self and dependents: Year 1: Full COBRA rate, if eligible; Year 2: Full COBRA rate, if eligible; Year 3: Full COBRA rate, if eligible.	provisions of COBRA for up to 18 months.	provisions of COBRA for up to 18 months.	self and dependents for duration of leave. Family Leave: Same cost as paid for Dental coverage by employees not on leave. Personal Leave/ Education Leave: Pay COBRA rates. Military Leave: In most cases, pay COBRA rates.	continue for you and eligible dependents at the same rate as employees for one year as long as you continue to qualify for disability and you pay the required premium. Thereafter, you may continue coverage at the COBRA rates for 18 months.	coverage continues at no cost for three months, with additional eligibility for COBRA for 33 additional months.
Short Term Disability Coverage						
Short Term Disability Plan	Coverage ends on your last day worked.	Coverage ends on your last day worked.	Coverage ends on your last day worked.	Coverage ends on your last day worked.	N/A	N/A

Benefit Plan	If You Are Laid Off (Reduction of Force – ROF)	If Your Employment Terminates	If You Retire (age 55 with 10 years of vesting service, hired prior to 1/1/2004)	Leave of Absence	If You Are on Disability	If You Die
Long Term Disability Coverage						
Long Term Disability Plan	Coverage ends on your last day worked.	Coverage ends on your last day worked.	Coverage ends on your last day worked.	Coverage ends on your last day worked.	N/A	N/A
Basic Life/Accidental Death and Dismemberment Insurance (AD&D)						
Basic Life/Accidental Death & Dismemberment Plan	Coverage continues for 31 calendar days after your last day worked. Or coverage can be extended up to one year after layoff by paying required premium. Conversion to private coverage is offered by the insurance company.	Coverage continues for 31 calendar days after your last day worked. Conversion to private coverage is offered by the insurance company.	Coverage continues for 31 calendar days after your last day worked. *Retiree Life Insurance Options.* If eligible, may enroll in retiree life insurance.	Coverage automatically continues for 31 calendar days after your last day worked. Coverage can be continued for up to 12 months (except as noted below) by paying the required premium. Family leave: Coverage for up to 12 weeks. Military family leave: Coverage for up to 26 weeks.	AD&D coverage continues for one year. Basic Life Insurance coverage continues with the Company paying required cost while on LTD.	N/A

Benefit Plan	If You Are Laid Off (Reduction of Force – ROF)	If Your Employment Terminates	If You Retire (age 55 with 10 years of vesting service, hired prior to 1/1/2004)	Leave of Absence	If You Are on Disability	If You Die
Dependent Life Insurance						
Dependent Life Insurance Plan	Coverage automatically continues for 31 calendar days after your last day worked. Or coverage can be extended up to one year after layoff by paying required premium.	Coverage automatically continues for 31 calendar days after your last day worked.	You can continue the coverage you have until age 65 by paying the required premium.	You can continue the coverage you have for one year of Leave by paying the required premium.	Coverage can continue for one year provided you pay the required premiums.	Dependent Life Insurance Coverage ceases.
Personal Accident Insurance (PAI)						
Personal Accident Insurance Plan	You can continue, for up to one year, the PAI coverage you have at the time of layoff by paying the required premium in advance.	Coverage ends on your last day worked.	N/A	You can continue the coverage you have for one year of Leave by paying the required premium.	Coverage can continue for one year provided you pay the required premiums.	N/A
Business Travel Plan	Coverage ends on your last day worked.	Coverage ends on your last day worked.	N/A	Coverage ends on your last day worked.	Coverage ends on your last day worked.	N/A

Benefit Plan	If You Are Laid Off (Reduction of Force – ROF)	If Your Employment Terminates	If You Retire (age 55 with 10 years of vesting service, hired prior to 1/1/2004)	Leave of Absence	If You Are on Disability	If You Die
Flexible Spending Accounts	You may qualify for continued coverage under COBRA provisions.	Same as ROF.	Same as ROF.	Same as ROF.	Same as ROF.	N/A
Severance Pay Plan	You may be eligible for Severance Pay.	You are not eligible.	You are not eligible.	You are not eligible.	You are not eligible.	N/A